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## Clinical Social Workers' Use of Self and the Impact of Personal Therapy on Practitioner Development

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# Clinical Social Workers' Use of Self and the Impact of Personal Therapy on Practitioner Development

by

Jessie C.W. Daley, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### **Abstract**

Social workers are as vulnerable as any human being to life's challenges and must sometimes seek professional therapy services to process. This study quantitatively investigates Licensed Independent Clinical Social Workers' (LICSWs) experiences with personal therapy on a personal and professional level. Qualitatively examined in this study are the following research questions: "How do LICSWs define "use of self" in clinical practice?" and "How do LICSWs' experiences in personal therapy relate to their "use of self" in clinical practice?" Data was gathered from 57 participants through an anonymous online survey. Quantitative data analysis revealed themes that mirrored findings present in the literature on the use of personal therapy, such as a high rate of utilization and positive perceived impact on personal and professional development. Qualitative data analysis revealed the following main themes: "'Use of self' means sharing myself with my clients through skillful self disclosure and empathy" and "'Use of self' means authentically bringing all I'm made of into the therapeutic relationship for use as a therapeutic tool," "Modeling of therapeutic behavior," "Greater self-awareness and personal growth/Awareness of issues related to countertransference," and "Having the experience of being a client."

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This paper is affectionately dedicated to my family: my husband Sean and my son Malcolm, for the steadfast love and encouragement, acceptance, and patience they have both shown throughout this process. You two are my heart and soul and light. Sean, thank you thank you thank you, extra, a million times, for all that you do to make our life work so well. I love you. To my parents, for their wisdom, enthusiasm, editing, and cheerleading; my in-laws for their strength, generosity, kindness, and belief in me, and both sets of parents for the unflinchingly loving role they have played in supporting my family with many incredible dinners and hours of tender hearted childcare throughout my graduate school career. I am so grateful.

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## **Clinical Social Workers' Use of Self and the Effects of Personal Therapy on Personal and Professional Development**

As social workers in a clinical mental health setting, we offer our service to clients as they seek to make sense of their dynamic inner worlds, to sort through the complexity of their emotional lives, to navigate hardship, process loss, grow through traumatic experience, and integrate change. We are in service to others, day in and day out, seeking to help, to heal, to encourage and support those in crisis or in need. As social workers, our own experiences with struggle, trauma, and suffering have often influenced our decision to dedicate our lives to serving others; universally, we will encounter our own sorrow, suffer our own losses, and will be surprised and overwhelmed by the weight that the world can sometimes throw upon our shoulders. Ethically, we have a responsibility to serve others from a position of wellness, to be aware of our values and judgments as we empathize with clients in practice, and to care for ourselves to prevent burnout, compassion fatigue, and vicarious traumatization. So where are we, as social workers, to turn when our *own* lives feel heavy, confusing, or out of control?

Therapists in many studies have heralded personal therapy as a powerful source of professional grounding and orienting both during clinical training, and throughout the lifespan of their careers (Wiseman & Schelter, 2001; MacDevitt, 1987; Mackey & Mackey, 1993; Macran, Smith, & Stiles, 1999; Oteiza, 2010). Mental health professionals throughout the literature have also mentioned the personal growth and healing they have experienced from involvement in personal therapy when dealing with stress, relationship issues, trauma, and other mental health concerns (Daw & Joseph, 2007; Grimmer & Tribe, 2001; Pope & Tabachnick, 1994). Participants in a study by Wiseman and Schelter

(2001) discussed the intersection of professional development and personal growth and/or healing as the development of the therapeutic “self”: “...all of our interviewees viewed self-knowledge, being a necessary requirement for practicing responsibly as a therapist, as an important goal and outcome of personal therapy” (p. 138).

Geller, Norcross and Orlinsky, (2005) define “personal therapy” as “a broad and generic term encompassing psychological treatment of mental health professionals (or those in training) by means of various theoretical orientations and therapy formats,” that can occur for any duration and that may be “either voluntary or required.” Personal therapy was first introduced by Freud as an essential part of clinical training (Geller, Norcross, & Orlinsky, 2005). Freud is famous in the literature on personal therapy for his rhetorical question: “But where and how is the poor wretch to acquire the ideal qualification which he will need in this profession? The answer is in an analysis of himself,” (as cited in Clark, 1986, p. 541).

In this study, I am interested in learning about why clinical social workers use personal therapy, in whether personal therapy has been influential on their personal and professional growth, and in whether personal therapy has fostered growth in the “self” they bring to the therapeutic relationship in clinical practice with others. I am also interested in how “use of self” is subjectively described by clinical social workers. For the purposes of this paper, I will use the term “mental health care practitioner” “mental health care provider,” “practitioner,” “therapist,” and “clinician” interchangeably to refer to a professional from any discipline or theoretical background who is licensed to conduct group or individual therapy with clients. I will use “clinical social worker” to

specifically describe a social work clinician who works in a mental health care setting providing group, couples, family, or individual therapy to clients.

### **Literature Review**

There have been numerous studies conducted both qualitatively and quantitatively on various aspects of the use of personal therapy by mental health care practitioners across disciplines. On the following pages, I will present findings from my review of the literature on therapists' use of personal therapy.

#### **Prevalence**

Many studies have documented the widespread utilization of personal therapy by mental health professionals. Norcross and Guy (2005) reviewed 14 studies on therapists' use of personal therapy in the United States, and reported that approximately 75% of mental health professionals had engaged in personal therapy at some point in their lives. Their study also examined personal therapy utilization as it relates to theoretical orientation, professional activities, therapist gender, and marital status. Personal therapy in the United States, overall, is most highly correlated with psychoanalytic or psychodynamic orientations, private practice settings, female gender, and married status (Norcross & Guy, 2005; Pope & Tabachnik, 1994; Prochaska & Norcross, 1983; Mackey & Mackey, 1993)

Bike, Norcross, and Schatz (2009) found similarly high utilization of personal therapy by mental health professionals in their survey of practitioners on their respective experiences with personal therapy. Their results revealed that a staggering 84% of their 727 respondents had engaged in at least one episode of personal therapy during their



lifetime. Similarly, Pope and Tabachnik (1994) reported an 84% lifetime utilization rate amongst the 476 psychologists surveyed in their study, and Liney and Joseph (2007) found that 78% of the 156 practitioners they surveyed had sought personal therapy in the past.

The results of studies conducted in the United States suggest broad usage of personal therapy by therapists. In attempt to explore the use of personal therapy by mental health professionals on a global scale, Orlinsky, Ronnestad, Willutzki, Wiseman, Botermans, and the SPR Collaborative Research Network (2005) surveyed 5,000 practitioners from 14 different countries worldwide. They found similarly widespread utilization of personal therapy in countries across the world, with greatest prevalence amongst therapists in France (98.9%) and the least amongst therapists in South Korea (36.1%). Results of a study by Daw & Joseph (2007) also support findings that personal therapy has been used by a majority of therapists worldwide.

### **Reasons for Seeking Personal Therapy**

As professionals who help people to navigate various challenges and transitions in life, therapists are, of course, still vulnerable to their own personal, professional, and philosophical hardships and dilemmas. Heery and Bugental (2005) highlight a myth prominent in the mental health profession: “that a practicing psychotherapist has crossed some threshold and is now above needing help himself or herself” (p. 283). They go on to assert that “a psychotherapist is not a god who knows all, but rather an individual accompanying others on a full – and often painful – human journey” (p. 283). While historically, personal therapy has been associated with therapeutic training and ongoing

supervision, most research reveals that therapists' most common motivations to seek their own therapy are either personal in nature or arise from a combination of personal and work-related issues (Bike et al., 2009; Daw & Joseph, 2007; Mackey & Mackey, 1993). A relatively low number of therapists seek their own therapy solely in the interest of training or processing work-related stress (Bike et al., 2009; Norcross & Connor, 2005)

A number of studies have investigated these precursors to practitioners' engagement in personal therapy (Norcross & Connor, 2005; Deacon et al., (1999); Daw & Joseph, 2007; Bike et al., 2009; Orlinsky et al., 2005; Liaboe, Guy, Wong, and Deahnert, 1989 (as cited in Norcross & Connor, 2005)). Norcross and Connor (2005) conducted a review of past research done on therapists' motivation to seek their own therapy and found that in all studies in their sample, psychotherapists overwhelmingly sought their own therapy for personal reasons, rather than for professional or training purposes. Daw and Joseph (2007) found that "personal growth" and "personal distress" were the biggest motivators for therapists represented in their study to enter personal therapy (p.230).

In their survey on the processes and outcomes of therapists' engagement in personal therapy, Bike et al. (2009) found that 60% of their sample reported personal reasons behind their decision to pursue their own therapy, while only 5% reported professional reasons. In between these two groups, 35% of their sample reported some combination of personal and professional motivations. They took their exploration a step further by asking participants to select a more specific presenting problem, and found that the highest proportion of participants sought therapy for "Marital-couple distress" (20%), "depression" (13%), and "need for self-understanding" (12%). Also represented in this

sample were therapists who entered therapy to address issues related to “Anxiety-stress” (10%), “Adjustment Problems” (10%), and “Family-of-origin conflicts” (9%). A few participants cited the desire to address “Interpersonal conflicts” (5%), “Grief-loss” (2%), and “Alcohol-substance use” (1%). Only 9% of the sample reported entering therapy for reasons solely related to their careers, with 5% specifying “Training purposes” and 4% citing “Career concerns.” Deacon et al. (1999) studied licensed marriage and family therapists’ reasons for initiating personal therapy, and note that “it is interesting that problems and stressors that could be related easily to one’s profession and work were not seen by many respondents as “worthy” of therapy” (p. 82).

Running parallel to their findings are the findings of an earlier study by Liaboe et al. (as cited in Norcross & Connor (2005)), who investigated the factors influencing mental health practitioners to seek personal therapy. They found that therapists most often seek their own therapy as a means to alleviate stress from their personal lives, or to promote self-growth. Likewise, Holzman, Searight, and Hughes (1996) surveyed 1,018 clinical psychology graduate students on their use of personal therapy and found that students most commonly chose “personal growth” as their primary motivation for entering personal therapy.

The international study by Orlinsky et al. (2005) corroborates the research presented above, with “Personal growth” cited as the most common reason worldwide for entering therapy. The researchers suggest that this finding puts a hopeful spin on the classic conceptualization of motivation for seeking therapy: “When therapists indicate they had personal rather than professional reasons for entering therapy, they are not necessarily focusing on their problems in living or their psychopathology. There is also a

more positive aspect to therapists' motivation for therapy: self-improvement, personal development, and enrichment" (Orlinsky et al., 2005, p. 188). The most common value placed on personal therapy in a study of psychologists' use of personal therapy conducted by Pope and Tabachink (1994) was "not the accomplishment of a specific behavioral goal but rather was an increase in self-awareness or self-knowledge" (p. 256).

### **Resolution of Personal Dilemmas and Influence on Personal Growth/Development**

As mentioned above, becoming a mental health practitioner does not safeguard any therapist from his or her own encounters with sudden trauma, loss, relationship disturbances, and difficulty adjusting to new life circumstances (Carbonell & Figley, 1996; Deacon, Kirikpatrick, Wetchler, & Niedner, 1999). For example, 60% of the respondents in a study of marriage and family therapists indicated that they had their *own* marital struggles, 45% indicated that they struggled with depression, and 37% were dealing with issues related to grief at the time of the study (Deacon et al., 1999). In addition to being as vulnerable as non-therapists to sudden crises, therapists - as human beings - carry with them longstanding family-of-origin issues, unresolved conflicts, fears, and mental health diagnoses. In the study by Deacon et al. (1999), 44% of respondents indicated "family of origin" problems, 28% indicated "childhood issues" and 10% reported having been a victim of childhood sexual abuse.

It has been posited that mental health professionals have an ethical obligation to themselves and to their clients to maintain a reasonable degree of mental wellness and stability, such that their personal lives do not impede their judgment as professionals and their ability to deliver good care (Pope & Tabachnik, 1994; Smith, 2007; Wiseman &

Shefler, 2001). As discussed by Smith (2008), the Code of Ethics for the American Association of Marriage and Family Therapy (AAMFT), the Ethics Code of the American Psychological Association (APA), and the National Association of Social Workers (NASW) Code of Ethics all clearly state (in different terms) the ethical obligation to “seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others” in times of personal distress (NASW, 1999, Section 4.05). Smith (2007) described the space between individual personhood and professional self as “small if not nonexistent” (p. 46), and cites Macran, et. al, 1999, who suggest that “blind spots lead to ineffective if not damaging work with clients and these blind spots emerge because one has not “worked on [one’s] own issues” (pg. 47). A participant in a study by Macran et al. (1999) summarized this well by observing that “therapists need to take care of themselves psychologically if they are to work safely with clients” (p. 423).

Related to the “stuff” that a therapist brings with him or her to the therapeutic setting are transference and countertransference. Transference is commonly defined as a displacement of feelings and attachments from early childhood onto the practitioner in the therapeutic setting (Patterson, 1959). Macran, Smith, and Stiles (1999), brought transference issues to light in their interviews with 7 practicing therapists on the usefulness of personal therapy. One respondent commented on the valuable experience of being on the client side of the transference/countertransference dynamic by saying “unless you’ve experienced the ways that you can feel about your therapist, you really aren’t going to understand what is going on for your client” (p. 423). From a

countertransference perspective, Oteiza (2010) found that “personal therapy helped professionals to identify blind spots and deal with their own unresolved issues” (p. 423).

As outlined in the sections above, mental health professionals often turn to personal therapy to process personal issues. In times of personal distress, personal therapy may provide therapists with relief from symptoms or facilitate their return to a state of wellness. Eighty six percent of the participants in a study conducted by Pope and Tabachink (1994) found personal therapy helpful, a result that parallels the findings of other studies (Daw & Joseph, 2007; Deacon et al., 2010; Grimer & Tribe, 2001; Holzman et al., 1996; Linley & Joseph, 2007). Therapists in numerous other studies view personal therapy as a powerful means to overcoming personal distress, as well as addressing other issues that may otherwise become problematic in the transference/countertransference reactions that occur daily in the therapeutic setting (Linley & Joseph, 2007; Grimmer & Tribe, 2001; Oteiza, 2010; Rizq & Target, 2010).

In addition to the resolution of personal dilemmas, many therapists interviewed in qualitative studies mentioned “personal growth” or “personal development” as one of the most salient features of their experience in personal therapy. In a study conducted by Daw and Joseph (2007), 86% of the participants reported “personal growth” as the main purpose of their engagement in personal therapy. One participant reported “Through my experience of therapy I have been able to recognize patterns which have been unhelpful and start to change these in my life” (p. 230). Another participant in the same study said, “I have gained as a person and am able to see clearer about the motivations that drive me as a therapist” (Daw & Joseph, 2007, p. 230).

Respondents in the study by Grimmer and Tribe (2001) talked about personal growth in the context of professional development: "...it was all about becoming more acutely aware of yourself and of your issues and how your stuff can impact on your relationship with the client and how the client can impact on you as a professional" (p. 294). Likewise, Mackey and Mackey (1993) found that participants in their study "focused more on the inseparability of one's identity as a human being with how one is in professional roles with clients" (p. 106).

**Work Stress and Burnout.** Aside from acute or long-standing bouts of stress or hardship unrelated to their work environment, mental health professionals, particularly those who work with traumatized clients, are particularly vulnerable to work-related burnout, vicarious/secondary traumatization, and compassion fatigue (Cunningham, 2004; Bride & Figley, 2007; Kim & Stoner, 2008). In many studies, practitioners who engaged in personal therapy reported connection in some capacity between the time they spent in personal therapy and the prevention of burnout or exhaustion in their professional lives (Grimmer & Tribe, 2001; Linley & Joseph, 2007; Mackey & Mackey, 1999; Macran et al., 1999; Oteiza, 2010).

For example, Mackey and Mackey (1993) explored the connection between personal therapy and professional development by conducting personal interviews with 15 second-year MSW students and 15 MSW clinical social workers. Many respondents in their study mentioned their experience with personal therapy as an "antidote to burnout" (p. 106). Macran et al. (1999) cited "The opportunity to take care of self" as one of the themes that emerged through their interviews. One of their respondents said that, given the emotionally intense and demanding nature of the mental health profession, she found

it helpful “to have a place where I can go and just collapse and be whatever” (p. 423). Oteiza (2010) found that, according to participants, personal therapy “acted also as a filter to establish therapists’ emotional well-being” (p. 226). Grimmer and Tribe (2001) revealed that personal therapy was beneficial in preventing burnout by helping the therapist to separate his or her own issues from those of clients, thus preventing over identification with his or her clients in practice. A participant in a study conducted by Daw and Joseph (2007) stated that personal therapy was “a good way to grow personally and deal with the distress of the feelings generated through client work and external personal experiences” (p. 230). Finally, respondents in a study by Linley and Joseph (2007) revealed “more positive psychological changes and less burnout” as a result of supplementing work as a therapist with their own personal therapy (p. 398).

**Influence on Professional Development.** Although there is widespread debate over whether personal therapy should be mandatory in advanced training programs, therapists from varying disciplines who were required by their programs to engage in personal therapy or analysis have largely agreed that this requirement was a valuable part of their training experience and greatly influential on their development of a professional sense of self (Grimmer & Tribe, 2001; Rake & Paley, 2009). Grimmer and Tribe (2001) studied the impact of mandatory personal therapy on the professional development of trainees in a counseling psychology program and found that this requirement helped their subjects to develop “reflexivity” in relating to their own clients, facilitated their socialization into the professional role, provided them with “emotional support in times of crisis,” provided both positive and negative modeling of theories and practices learned in the classroom, and aided in their personal growth (p. 295).



Personal therapy unrelated to education or training has also been cited as an important contributor to professional sense of self (MacDevitt, 1987; Mackey & Mackey, 1993; Macran, Smith, & Stiles, 1999; Oteiza, 2010). Macran et al. (1999) identified the theme “Providing a role model” in their interviews with seven practicing therapists on their use of personal therapy. One respondent in their study summed this theme up by saying “In the same kind of way that in martial arts people actually talk about visualizing their master as a resource in a fight...I can actually draw on the memory of my therapist having done something really well in order to be more skillful myself in a difficult situation with a client” (Macran et al., 1999). Oteiza (2010) similarly identified “Having a professional reference: The therapist as a model” as a recurring theme in her conversations with 10 clinicians in Spain (p. 226). In another study, a respondent said “When I began to practice, I made interpretations using his phrases, I could hear his tone of voice, it amazed me constantly and delighted me to hear it coming out of me just the way he said it” (Mackey & Mackey, 1993). Other broad themes related to professional development that arose across studies include taking on the role of “client,” development of empathy, bringing theory to life, understanding transference and countertransference, and gaining a deeper understanding of the helping process (MacDevitt, 1987; Mackey & Mackey, 1993; Macran, Stiles & Smith, 1999; Oteiza, 2010; Daw & Joseph, 2007)

Therapists in some studies report that even *negative* experiences in personal therapy have been useful to their own practice (Grimmer & Tribe, 2001; Macran et al., 1999). For instance, in one study, the respondents commented that experiences such as listening to a therapist’s “overuse of cliché,” being pushed too hard to explore affective material before emotionally ready, and their therapist’s use of an interrogating style

helped them to recognize unhelpful and even harmful therapeutic behavior that they did not want to subject their own clients to (Grimmer & Tribe, 2001). A more in-depth example of negative personal therapy experience positively informing a therapist's professional practice is communicated by a subject in Macran et al.'s (1999) study, who described a therapist who initially encouraged her to go at her own pace in exploring some painful material, yet ignored explicit verbal messages that she was becoming overwhelmed while talking about it: "I'm always really careful to say to them [clients], "if you want to stop, if you don't feel able to say it, lift your hand up of whatever," because I know the experience of being in it....It's really made me think about the power that a therapist has" (p. 423).

### **Conceptual Framework**

**Use of Self.** The social work profession stands apart from the other therapeutic professions in that it's values espouse to commitment to social justice, service to underserved populations, and micro- mezzo- and macro- level practice. Another important sub-text that runs through all of social work practice is the standard allegiance to the authentic use of self in the therapeutic relationship. While many mental health professions describe the "use of self" as a meaningful and necessary tool in practice, the social work profession prides itself on training and practice grounded in self-reflection, self-knowledge, and the awareness of personal value structure in relation to clients and systems at the micro- mezzo- and macro- levels.

"Use of self" is often mentioned in social work training and practice. However, it remains a somewhat vague and ambiguous concept, with no finite definition and plenty

of room for interpretation. As described by Reupert (2007), the ‘self’ is a social worker’s tool, “just as artists use paint and carpenters use a hammer,” (p. 18) and is his or her most powerful medium for the facilitation of change and healing (p. 107). As reflected in the common axiom “Physician heal thyself,” social workers must keep their “instrument” tuned and sharpened, easily accessible and thoroughly examined (Dewane, 2006).

Although there is no simple, tightly packaged way to describe a social worker’s “use of self,” Dewane (2006) suggests that “use of self” can be operationally defined in five ways: “Use of personality,” “Use of belief system,” “Use of relational dynamics,” “Use of anxiety,” and “Use of self-disclosure” (p. 544). “Use of personality,” for instance, encompasses “self-knowledge”: the examination of “personality traits and behavioral patterns” in relation to our career choice, and modes of operation within our field and within the therapeutic context (p. 545). She proposes that the illumination of different aspects of our living, breathing, loving, and suffering human selves can greatly inform and shape our practice in service to others. “Use of anxiety,” as another example, can be described as the therapist taking an active interest in his or her own anxiety while in session with a client, and using that anxiety when appropriate by tactfully exploring the meaning behind its presence in sessions. Finally, “Use of self-disclosure” is discussed as the most well-known but controversial definition of “use of self.” Guidelines for self-disclosure such as: “Self disclosure must lead to [client] growth,” and “Self-disclosure should never occur without first analyzing what and how much of the responses belong to whom. Know thyself,” are presented as important factors for a therapist to hold in awareness when employing this definition of “use of self” in the therapy room.

A substantial perspective on “use of self” is presented by Arnd-Caddigan and Pozzuto (2007), who challenge the common definition of “self,” which posits the therapist as “a freestanding being that is self-contained - though at times in interaction with other such entities - and relatively stable or constant” (p. 235) by conceptualizing the therapist’s “self” as “a function of relationships with others in which the self is continually created, maintained, and re-created” (p. 235). Their idea, with roots in neuroscience, attachment theory, and sociology, is that “use of self” in therapy changes based on the fluctuating environment of the therapeutic relationship, and is comprised of all relational interactions – real or imagined – that have led up to the current moment (p. 236). The relational context of therapy, then, creates a space for the spontaneous reworking of “self” based on the dynamics and demands of the current interaction. They argue that this new definition of “self” brings client and practitioner into an interaction that is less hierarchical, thus creating an atmosphere less focused on “fixing the other” and more focused on creating a culture of service to the other (Arnd-Caddigan & Pozzuto, 2007). This concept is akin to the theory of intersubjectivity: the idea that the “self” in relation to others is created moment-by-moment through a mutual exchange of emotional and sensory information, which in turn creates a shared mental landscape via the firing of mirror neurons in the brain (Balbernie, 2007). However, a qualitative study by Rupert (2007) did not produce evidence for a flexible, externally motivated, and relationally driven sense of self. Rather, the social workers represented in her study discussed their professional “self” as “individualistic, central and unique, and only somewhat defined by others and the context in which they worked” (p. 112).

Edwards and Bess (1998) argue that “the application of *what you know as a psychotherapist* (that is the accumulation of knowledge and techniques from professional education and training) can only be helpful and effective if you are aware of how *who you are as a person* in the room with the client (that is the accumulation of your own personality traits, personal belief systems, and psychology in the relational matrix with the client) is influencing the therapy” (p. 89). Personal therapy has been touted, through various theoretical orientations (namely psychoanalytic) and throughout the literature as a powerful mechanism toward personal and professional growth, self-discovery, and the creation of meaning. From the quote above, we can interpret an intersection of “personal therapy” with “professional use of self.” As an agent of change and growth, personal therapy may be an important means toward a therapists’ development of a cohesive “self,” which can be used therapeutically in compassionate service to clients.

### **Summary and Research Focus**

Personal therapy is widely used by therapists hailing from all theoretical backgrounds. It has been touted as a fundamental part of training, an important means to development as a professional, and a potent aid in the relief of personal suffering. By seeking personal therapy, therapists have reported a relief of symptoms, positive behavioral and cognitive changes, resolution of dilemmas, and enhanced professional awareness. The literature on “use of self” in therapy is still quite limited. However, the research available at present clearly suggests that the “use of self” is an important area of research focus, as “use of self” is inherently part of the work we do as clinical social work practitioners, and part of our professional identity.

While there has been much research focused on the therapist's use of and experience with personal therapy, few studies have specifically focused on the personal therapy experiences of clinical social workers. In this research paper, I am interested in clinical social workers' experiences of personal therapy, how clinical social workers subjectively understand the "use of self," and whether or not personal therapy has had an influence on their "use of self" in professional practice.

### **Methods**

After deliberating on the use of a qualitative, open-answer format survey to collect data, I chose a largely quantitative approach to this project, with the exception of two qualitative questions. Although I believe that a qualitative approach to the project in its entirety would have provided a greater abundance of vibrant, rich data, I chose to transform my qualitative questions into a quantitative format, in hopes of making the survey more appealing and less time-intensive for potential participants. I chose to design an online questionnaire through Qualtrics, anticipating that the ease in access (respondents simply click on a link to access questionnaire), and assured anonymity would foster a good response rate.

### **Sample**

I used a systematic random sampling approach to recruit participants (Berg, 2009). I chose to survey Licensed Independent Clinical Social Workers (LICSWs) specifically because they are most likely of all social workers to engage in clinical practice. After receiving a random sample of 999 LICSWs in the state of MN from the Minnesota Board of Social Work along with their email addresses, I started my sampling process by dividing the list of names by 150. Based on this equation, I started at the beginning of the

list, and sampled every 6<sup>th</sup> person. This gave me an initial sample of 150. When responses were initially slow to come in, I decided to sample another 100 LICSWs in the same manner as the first. This boosted my sample size to 250 LICSWs total.

I posted a link to the online survey in the emails I sent to all potential participants. In the email I explained the purpose of my study as well as the risks and benefits involved in participation. I explained that their responses would be entirely anonymous and that their participation was voluntary.

Of 250 LICSWs contacted via email, 58 clicked the link to take the survey, and 57 proceeded with the survey. These respondents were between the ages of 31 and 73; 88% of respondents were female, and 12% were male. When asked “How many years have you been in clinical social work practice?,” 10% of respondents indicated “1-5 years,” 17% indicated “5-10 years,” 30% indicated “10-15 years,” 10% responded “15-20 years,” and 26% responded “20+ years.” In response to the demographic question “What type of therapy do you practice in your current setting? Please answer yes or no to each item,” respondents answered as indicated in Table 1 below.

Table 1

*Type of therapy respondents reported practicing in current setting.*

<b>Type of therapy practiced in current setting</b>	<b>Total # and percentage of participants who responded YES</b>	<b>Total # and percentage of participants who responded NO</b>
Individual – Adult	32 (80%)	8 (20%)
Individual – Child	15 (45%)	18 (54%)
Individual – Adolescent	22 (59%)	15 (41%)
Family	20 (59%)	14 (41%)

Couples	15 (45%)	18 (55%)
Group work – Adult	15 (44%)	19 (56%)
Group work – Child	6 (21%)	22 (79%)
Group work – Adolescent	4 (13%)	26 (87%)

*Note:* The few respondents who chose “Other” are not represented in this table. They indicated working in other capacities, such as “Hospital Social Work,” “DBT,” “Geriatric,” and “Infant-toddler mental health,” amongst others.

### **Instruments**

The research instrument I used for this study was an online survey powered by Qualtrics, comprised of seven closed-ended, multi-part questions and two open-ended questions designed to investigate respondents’ use of personal therapy, the “use of self” in therapy sessions with clients, and the intersection of the two. I opened the survey by obtaining informed consent from each participant by giving in-depth information about the survey, including risks and benefits to participation, and then asking participants for their consent to participate. Once participants had given their consent, they were prompted to read the operational definition of “personal therapy” used in this study and then to answer a series of questions about their own experience with personal therapy. Likewise, the questions on “use of self” began with an orienting statement to the concept “use of self.”

At the beginning of the survey, participants were asked: “Have you ever sought personal therapy?” If they have had experience in personal therapy, they were prompted to answer seven closed-ended questions on their experience in therapy, and then to



answer one open-ended question on “use of self,” one closed-ended question on “use of self,” one open-ended question on the intersection of the two, plus four demographic questions. If they have *not* had experience in personal therapy, they were prompted to answer only the open-ended question on “use of self,” which is relevant to all clinical social workers regardless of their experience in personal therapy, and then to answer four demographic questions.

The survey questions above were peer- and research committee-rated for reliability in answering my research questions: “How do clinical social workers experience personal therapy?” “How do clinical social workers subjectively understand the “use of self?” and “Does personal therapy have an influence on clinical social workers’ “use of self” in professional practice?” The questions were also reviewed to explore their reliability in answering questions related to basic demographics, and in providing insight into the general reasons that LICSWs decide to engage in personal therapy. To give my peers the opportunity to review the survey questions, I distributed paper copies of the online survey to my fellow research practicum colleagues, and asked them to provide feedback on questions/survey items that may be poorly worded or otherwise confusing. (See Appendix A for Survey).

## **Data Analysis**

### **Quantitative data**

Qualtrics software is designed to run statistics on the quantitative data collected. Descriptive statistics were automatically run on all quantitative data collected. Findings were summarized in form of a percentage distribution on responses to each question.

### **Qualitative data**

I used deductive content analysis to interpret the qualitative data I collected in response to the survey questions: “What does “use of self” mean to you as a clinical social worker?” and “Please elaborate on how personal therapy has affected your “use of self” in clinical social work practice,” and also to analyze any closed-ended questions that respondents chose to elaborate upon in the space given. A definition and description of this process follows. I copied and pasted participants’ responses to the aforementioned questions into a Word document. This created a more structured and cohesive format for analyzing the data. After all responses were transferred into a printable format, they were analyzed using *content analysis*. As defined by Berg (2009), *content analysis* is “a careful, detailed, systematic examination and interpretation of a particular body of material in an effort to identify patterns, themes, biases, and meanings.” Here, the body of material was the collection of words and sentences gathered from participants’ typed responses to the qualitative survey questions: “What does “use of self” mean to you as a clinical social worker?” and “Please elaborate on how personal therapy has affected your “use of self” in clinical social work practice,” as well as any closed-ended questions that participants chose to elaborate on in the Qualtrics survey. To give me a visual of my process in analyzing the data, I took large sheets of white paper, and drew four columns on each sheet. The columns were titled: “Emerging Themes,” “Response Number,” “Sub-themes/Observations,” and “Key Words and/or Phrases.” With a notebook and pen in hand, I numbered each individual response for coding reference, and then read and re-read each one until it’s meaning emerged, based on my subjective interpretation. I rewrote each response as if it were a theme or themes and then looked at the whole list of “Themes” I had written in my notebook, in order to identify clusters of similar ideas. I

then picked two or three of the most inclusive theme titles for each cluster and transferred them onto my large sheet of paper, into the column titled “Emerging Themes.” I re-read the responses, writing the reference number of the response next to the theme or themes it represented. I also pulled key words and quotes from each response, and wrote them in the column headed “Key Words and/or Phrases.” As I looked over this grid, I noticed deeper patterns, which I took note of in the column titled “Subthemes/Observations.” I reported the themes I observed in my “Findings” Section, and included comments from participants that exemplified each theme, as well as comments that represented unique perspectives and/or experiences.

### **Protection of Data**

All survey data was anonymously recorded by Qualtrics survey software. To keep all participants’ responses confidential, I stored all data in a password-protected electronic database. Data transferred to a Word Document for inclusion in this paper was kept on a password-protected computer. Only I knew these passwords, and thus was the only person with access to the data. Only non-identifying demographic information was collected, and even this non-identifying information was kept separate from survey data. All surveys remained anonymous. It was made clear in the email sent to participants that their participation in this study was entirely voluntary, and that the purpose of the study was exploratory in nature.

### **Risks and Benefits to Participants**

The only risk involved for participants was the possible recall of troubling events, if the survey happened to touch upon any part of personal therapy that a subject found distressing. All but one question related to personal therapy were multiple-choice format,

allowing participants to respond while simultaneously maintaining a greater emotional distance from the material than would be possible if a live interview or a fully open-response format was used. Participants were made aware that they could skip any questions they did not wish to answer. Also, the population sampled - LICSW therapists – were assumed to have a professional standing knowledge of the therapeutic process, some basic self-care skills, and support networks in form of supervision and consultation. Thus, I judged that the human subjects involved in this study were at low-risk for any harm resulting from participation. There were no benefits to participation in this study, aside from contribution to the body of research on therapists' use of personal therapy and research on “use of self” in clinical practice.

### **Limitations of Study Methods**

There were several limitations to this study. First and most obviously, I only sampled LICSWs from Minnesota. Therefore, I am unable to generalize my results to social workers across the United States and throughout the world. Also, my sample size was relatively small due to the time limitations assigned to this project. In addition, as mentioned in the introduction to this section, I chose a largely quantitative rather than qualitative format for my research. While I believe that the quantitative format of my survey increased my sample size by making participation more appealing (shorter time commitment, less intellectually demanding, and less emotionally charged), I believe that a qualitative approach: either by conducting live interviews or by offering an open-ended question survey format, would have provided me with more spirited, spontaneous data in form of reflections from participants on their engagement in personal therapy. Finally, one respondent, who had two very different experiences in personal therapy – remarked

that he or she found the survey distracting, as it did not allow him or her to make a distinction between these episodes of therapy.

## **Findings**

### **Quantitative Findings**

Of the 57 LICSWs who took the survey, 43 (77%) reported that they had sought individual personal therapy, based on the operational definition I provided at the beginning of the survey. Within this sample, 11 respondents (25%) indicated that they had been in therapy in the past 5 years, and 8 (18%) indicated that they were currently in therapy; 8 respondents (18%) had been in therapy 5-10 years ago, 3 respondents (7%) had been in therapy 10-15 years ago, 9 respondents (20%) had been in therapy 15-20 years ago, and 5 respondents (11%) had been in therapy 20+ years ago.

As you can see in Table 1, the top four reasons respondents selected for seeking personal therapy were “Personal problems” (77% yes), “Stress in personal life” (71% yes), “Emotional problems” (67% yes), and “Marital (or other intimate relationship) problems” (60% yes). Other reasons participants selected for seeking personal therapy are shown in Table 2.

Table 2. *Reasons for seeking personal therapy.*

<b>Reason for Seeking Personal Therapy</b>	<b>Total # and percentage of participants who responded YES</b>	<b>Total # and percentage of participants who responded NO</b>

Personal Problems	27 (77%)	8 (22%)
Stress in personal life	27 (71%)	11 (28%)
Emotional problems	24 (67%)	12 (33%)
Marital (or other intimate relationship problems)	24 (67%)	12 (33%)
Life transition	21 (60%)	14 (40%)
Personal growth	20 (57%)	15 (43%)
Family difficulties	13 (37%)	22 (63%)
Work related stress	13 (37%)	22 (63%)
Grief/loss	12 (34%)	23 (66%)
Other interpersonal problems	10 (29%)	24 (70%)
Clinical training	8 (24%)	25 (76%)
Substance abuse	2 (6%)	29 (91%)
Do not wish to answer	1 (10%)	9 (90%)
Infertility	1 (3%)	31 (97%)

In response to the question “Do you feel that personal therapy was helpful to

you?,” 35 respondents (80%) selected “Yes, personal therapy was helpful to me,” and 9 respondents (20%) chose “I have had both good and bad experiences in personal therapy.” None of the respondents chose “No, personal therapy was not helpful to me.” When asked to answer yes or no to a series of items describing *how* personal therapy might have been helpful, the most popular responses were “Positive cognitive changes” (95% yes), “Positive affective changes” (86% yes), “Better understanding of self” (85% yes), and “Enhanced personal growth” (83% yes). Other ways that respondents found personal therapy helpful can be found in Table 3.

Table 3. *Ways that respondents found personal therapy helpful*

<b>How personal therapy was helpful</b>	<b>Total # and percentage of participants who responded YES</b>	<b>Total # and percentage of participants who responded NO</b>
Positive cognitive changes	39 (95%)	2 (5%)
Positive affective changes	36 (86%)	6 (14%)
Better understanding of self	35 (85%)	6 (15%)
Enhanced personal growth	35 (83%)	7 (17%)
Better relationships	33 (80%)	8 (20%)
Alleviation of symptoms	32 (78%)	9 (22%)
Positive behavioral changes	31 (78%)	9 (22%)
Better self-image	29 (71%)	12 (29%)

Resolution of past trauma	15 (37%)	25 (63%)
Resolution of grief	12 (31%)	27 (69%)
Other	3 (N/A%)	0 (N/A%)

Responding to the question “Do you feel that personal therapy has had an impact on your professional development?,” 40 LICSWs (93%) marked “yes” and 3 (7%) marked “no.” Participants were then asked to respond to a series of statements on *how* personal therapy has impacted their professional development, by answering “yes” or “no” to each statement. The top statements that participants chose were: “Personal therapy provided me with an outlet for self-care” (87% yes), “Personal therapy helped me to respect my clients and their process in therapy” (83% yes), “My therapist served as a model for how to interpersonally conduct practice (82% yes), and “Personal therapy helped me to better empathize with my clients and their process in therapy (79% yes). Other statements that participants chose can be found in Table 4 below.

Table 4. *Ways personal therapy has impacted the professional development of LICSWs*

<b>Statements about impact of personal therapy on professional development</b>	<b>Total # and percentage of participants who responded YES</b>	<b>Total # and percentage of participants who responded NO</b>
“My therapist served as a	29 (73%)	11 (28%)



model for how to professionally conduct practice”		
“My therapist served as a model for how to theoretically conduct practice”	24 (60%)	16 (40%)
“My therapist served as a model for how to interpersonally conduct practice”	32 (82%)	7 (18%)
“Personal therapy helped me to better understand my clients and their process in therapy”	29 (74%)	10 (26%)
“Personal therapy helped me to better empathize with my clients and their process in therapy”	30 (79%)	8 (21%)
“Personal therapy helped me to better trust my clients and their process in therapy”	26 (67%)	13 (33%)
“Personal therapy helped me to better respect my clients and their process in therapy”	33 (83%)	7 (18%)
“Personal therapy oriented me to the role of a therapist”	27 (71%)	11 (29%)
“Personal therapy helped me to understand the therapeutic process”	28 (74%)	10 (26%)
“Personal therapy helped me to understand how my personal life influences my professional life”	29 (73%)	11 (28%)

“Personal therapy helped me to better understand the therapeutic relationship”	31 (78%)	9 (23%)
“Personal therapy helped me to better understand transference and/or countertransference”	23 (59%)	16 (41%)
“Personal therapy provided me with an outlet for self-care”	33 (87%)	5 (13%)
“Personal therapy had a negative impact on my professional development”	18 (45%)	22 (55%)

## Qualitative Findings

### Qualitative Question #1: “What does ‘use of self’ mean to you as a clinical social worker?”

Forty eight respondents chose to answer the open-ended question “What does ‘use of self’ mean to you as a clinical social worker?.” Most responses were one to two sentences long, with the exception of one response, which was more detailed and in paragraph form. In the following section, I will describe the themes that emerged during my analysis of LICSW’s responses to this question.

***Theme 1: “Use of self” means sharing myself with my clients through skillful self-disclosure and/or empathy:*** This theme was identified in 25 of the 48 responses. LICSWs who wrote about ‘use of self’ from this perspective conceptualized ‘use of self’ most often as: *Self-disclosure* (about life experiences, personal history, personal

information, or here-and-now feelings and thoughts that come up in session) and also as *Empathy* (arising when the LICSW is able to internally reflect on his or her own personal history and experiences in order to relate to the client's experience). Examples of quotes exemplifying each of these subthemes are outlined in the following paragraphs.

*Self-disclosure:* Many respondents defined 'use of self' as "judicious" and "skillful" self-disclosure about a therapist's own "life experiences," "life lessons," "personal history," and "personal information" in the interest of supporting the client in some way. One LICSW wrote that 'use of self' meant "Judicious self-disclosure of examples from my own life or my own feelings or experiences used in a therapeutic way to help the client." Another respondent felt that using "self" through self-disclosure helped to show understanding and non-judgment: "I...can say beyond a doubt that strategically sharing stories from my own past personal life has enabled my client to know that not only am I "human," but that I am not judging them." Another saw 'use of self' as a self-disclosure of here-and-now feelings in a therapy session when he or she commented that 'use of self' meant: "The intentional and planned use of therapist intervention as it pertains to the client situation. For example, the therapist may say, 'what you are describing, creates a bit of anxiety in me just hearing your experience, so tell me, how difficult was it for you, being right there, while this was happening'."

*Empathy:* Other respondents understood 'use of self' as a utilization of personal life experience to create a culture of empathy in the therapeutic relationship, without disclosing anything specific about his or her own life. For example, one respondent felt that 'use of self' meant: "Awareness of ones personal bias, experiences, and history to inform ones practice and empathy with clients." Another LICSW remarked: "for me, use

of self means the clinician is able to have a healthy, balanced, empathetic approach to client interactions, based on the clinician's past experiences." Some LICSWs understood 'use of self' in terms of both self-disclosure and empathy, as is stated most concisely in this comment: "Sometimes [it's] sharing experiences, sometimes it's putting myself in their shoes and thinking about how it felt to me so that I can join the client and try to understand their point of view better."

***Theme 2: "Use of self" means authentically bringing all I'm made of into the therapeutic relationship for use as a therapeutic tool.*** This theme was also found in 25 of the 48 responses. LICSWs who described "use of self" in this light had slightly varied definitions for "self." In general, these respondents felt that the "self" was some combination of "physical self," "emotional self," "spiritual self," "value-structure or value-awareness," "education," "personality," and "beliefs," and that bringing this wholeness of personhood to the therapeutic relationship was important to successful therapeutic connection and positive therapeutic outcomes. One respondent said: "it means when my education, my professional experiences, my life experiences, and my personal strengths all come together to build a professional relationship with a client and to assist that client, with their change." Another shared: "I bring my self/my life experiences to the client relationship and this includes the whole of who I am (i.e. physical, emotional, spiritual). Although I always need to be cognizant of my role and maintain appropriate boundaries, I'm keenly aware that my life experiences serve to enhance my clinical skills in many ways." Finally, one respondent felt that "use of self" meant: "Using my knowledge, life experiences, and personality to benefit therapeutic connection with clients."

*Authenticity:* Many respondents talked about “use of self” as an authenticity that they bring into the therapeutic relationship. In fact, one respondent’s definition of “use of self” was simply “genuineness.” Another respondent expanded: “As clinicians, we must use ourselves as the “instruments” of our work. “Use of self” to me means that I have a zone of self that can be called upon to address the needs of a client. It is an “authentic” part of me that I use in a therapeutic alliance with a patient, toward therapeutic goals.” Another stated: “Being genuine, authentic, and use of parallel process are all that incorporate “use of self” in therapy.”

*Therapeutic Relationship:* Respondents also talked about the importance of the therapeutic relationship itself. One stated simply that “use of self” meant: “That change and healing happen in the context of relationships.” Others commented on the importance of relationship in a similar manner. One shared: “Clients know when you care deeply about them and yearn for the acceptance they’ve never known in another relationship,” and another commented: “I know full well it’s not me who is healing them, it’s the relationship.” Another respondent stated: “We are in a real relationship with our clients. While it has clear boundaries, it is a real, intense, deeply personal relationship.” Almost all of the respondents who commented on the importance of the relationship also spoke to the importance of the therapeutic “self” within that relationship. One LICSW kept this idea short and sweet by commenting that he or she felt that “use of self” meant that: “I bring myself and my experiences into the therapeutic relationship.” The “self,” as defined by the weaving together of their individual descriptions, is all that the therapist brings to the therapeutic relationship to make it feel real, safe, genuine, and alive.

**Qualitative Question #2: “Please elaborate on how personal therapy has**

**affected your “use of self” in clinical social work practice.”**

As stated in the quantitative findings, 83% of respondents who had sought personal therapy in the past answered “yes” to the question “Do you believe personal therapy has had a positive effect on your “use of self” in clinical social work practice?” When respondents who answered “yes” were then prompted to elaborate on *how* personal therapy affected their “use of self” in clinical social work practice, 25 participants gave written responses. Many of these respondents seemed to speak more generally to how personal therapy affected their practice, rather than to how personal therapy specifically affected their “*use of self*” in clinical practice. Nonetheless, I extracted three separate themes from their responses.

***Theme 1: Modeling of therapeutic behavior and therapeutic “use of self”:*** Nine of the 25 LICSWs who responded to this question felt that personal therapy had served as a model of what therapeutic behaviors and interventions felt helpful or unhelpful from a client perspective. One respondent said: “The positive impact of the parallel process that occurred in therapy was impactful to me. My therapist was genuine, caring and empathic, which were strong qualities of “use of self” which helped me connect and feel comfortable in therapy to share difficult issues about self.” Some LICSWs relayed that their own therapy directly impacted how they themselves conducted therapy. One LICSW commented: “What worked for me became incorporated into what works for my own clients.” Another wrote: “My therapy was before my LICSW so the good way that the therapist used self was a good example for me,” and another shared: “...my style is very much based upon the one that saved my own life so many years ago.” Finally, one LICSW wrote: “I could get a sense of what did and what did not feel helpful to me in my

own therapy experience with my therapist's use of self, and I reflected on that for added knowledge of what to do and what not to do in session with clients."

The idea that personal therapy could serve as a model not only for healthy therapeutic behavior, but also for therapeutic behavior that felt unproductive or *unhelpful* was mirrored by two respondents who commented on how negative experiences in personal therapy taught them what *not* to do as a therapist. One recalled: "I once worked with a therapist who was so rigid and used so little of herself in the therapy I could not trust her and quite quickly terminated to see another therapist. It taught me what overdoing and rigid boundaries can do and how they can impact the relationship." Another had the opposite experience, with a therapist or therapists who shared *too* much: "I have learned that therapists that talk too much about themselves are annoying. They seem to make assumptions about my life experiences based on their own. I want them to listen to me rather than talk about themselves, even if they think it's relevant."

Finally, two respondents spoke specifically about the modeling of self-disclosure, echoing a subtheme mentioned above: "Through my own therapy, I understood the power of a therapist's self-disclosure (when appropriate); my therapist modeled good behavior, and I realized that self-disclosure is okay at times when it is authentic and genuine and used to help the client. Now, I am not scared to use appropriate self-disclosure at times to help my clients." Another said: "I have a better awareness of myself and how I impact my clients in how I am and how I use any self-disclosure."

***Theme 2: Greater self-awareness and personal growth/Awareness of issues related to countertransference:*** Thirteen of the 25 LICSWs who responded to this

question recounted the impact that personal therapy had had on their ability to work through their own issues and self-reflect, which left them with a feeling of greater self-awareness. One respondent said: “Foremost, my personal therapy helped me to “individuate” as a 20-something, and to develop a capacity to reflect on my internal process. This allowed the long trajectory of maturation as a therapist, in which I learned to show restraint in the face of anxiety – my own and the patient’s. This is the foundation, in my opinion, of thoughtful therapeutic action.” Another LICSW shared that personal therapy “motivated me to grow and work on my own issues,” and another felt that he or she had “benefitted in my own growth as a person, so that I can be more empathetic and effective in helping those I work with.” Yet another shared: “personal therapy has led to greater understanding of my sense of self, with greater empathy.” One LICSW also mentioned that personal therapy facilitated “more access to my own feelings; more awareness of my typical patterns of resistance that may get in the way of being able to fully establish a helping relationship.”

In turn, many respondents who wrote about developing greater self-awareness in personal therapy also commented on the subsequent ability to manage countertransference reactions with their own clients. One LICSW wrote that personal therapy gave him or her the ability “to resolve my issues so as to not guard my own emotions for fear of being triggered by clients.” Another stated: “My awareness of myself helps me to be more open with my clients when I am having a strong reaction during the therapy session, or for that matter, no reaction at all.” Two respondents wrote about being able to better manage countertransference reactions after resolving their own trauma in personal therapy. One wrote: “[Personal therapy] has helped me to work through and



resolve trauma so that if it comes up with a client I can use it in a healthy way given my work at resolution. Also helps me to observe countertransference reactions rather than acting on them,” and another wrote: “It allowed me the opportunity to resolve trauma that may have otherwise impeded my work with others...” Finally, one respondent said that after having been in personal therapy: “I feel like I have clearer boundaries. I am clearer about what are my client’s issues and what are my own.”

***Theme 3: Having the experience of being a client:*** Of the 25 respondents who chose to answer this question, 9 wrote about the value of spending some time in the role of the client. One LICSW shared: “I recognize the risk and level of courage necessary to seek therapy. This gives me an appreciation for how vulnerable people seeking services are.” Another commented: “To sit in the “other chair brings the therapeutic relationship to another level. I realize the impact of that relationship and the pluses and minuses and how important it is to be ‘real’.” One LICSW mentioned “becoming more self-aware and understanding the internal and external processes that a client goes through in seeking and receiving therapy,” and another shared that it allowed him or her “to know the process of therapy from the client’s perspective offering me the opportunity to recall it.”

## **Discussion**

My original interest in conducting this study was to explore clinical social workers’ use of personal therapy. My interest in clinicians’ “use of self” came about as I refined my research focus with the addition of a conceptual framework. After reviewing the literature on “use of self” and realizing how thin the empirical research is on this subject thus far, I decided to make the exploration of this concept a bigger part of my study.

While many of the bare-bones statistics and themes that surfaced in the current study paralleled those found in my review of the literature on clinicians' utilization of personal therapy, a few unique results arose from my qualitative questions on "use of self." In this section, I will discuss the parallels between the results of the current study and the existing literature, and will also discuss possible implications of some of the more noteworthy findings on clinical social workers' "use of self."

### **Personal Therapy**

The sample of LICSWs in this study reported using personal therapy at a rate comparable to rates of utilization found in larger samples of mental health professionals across various disciplines (Norcross & Guy, 2005; Bike, Norcross, & Schatz; Pope & Tabachnik, 1994; Liney & Joseph, 2007). Also, consistent with previous research (Norcross and Connor, 2005; Bike et al., 2009; Daw and Joseph, 2009; Mackey & Mackey, 1994), most LICSWs in my sample reported seeking personal therapy for reasons largely related to personal and interpersonal functioning rather than for reasons related to professional development or work stress. It struck me as interesting and heartening that "Personal *growth*" was one of the top reasons that LICSWs in this study chose for seeking personal therapy, corroborating the findings of a worldwide study conducted by Orlinsky et al. (2005). This may suggest that LICSWs are seeking personal therapy not only to alleviate stress, pain, and suffering, but also to enhance the experience of being human by working to develop a greater sense of self.

**Personal therapy in training programs.** It is noteworthy that a substantial number of participants indicated that personal therapy has had a positive impact on their

professional development in some way, both in the quantitative and qualitative sections of the survey. Given the overwhelming evidence suggesting that personal therapy is beneficial to practitioners, it is surprising that the practice of doing one's "own work" has trailed off as a mandatory or highly recommended part of professional training programs. In this study, only 8 respondents indicated that they had sought personal therapy as a part of clinical training, and none of the 58 respondents indicated that personal therapy had been an MSW program mandate. Although there is a lack of evidence showing that the *clients* of practitioners who have used personal therapy have better treatment prognosis, the research suggesting that practitioners *themselves* benefit from personal therapy, both personally and professionally, seems to indicate that personal therapy should be a more salient topic of conversation in professional training programs across disciplines, including but not limited to clinical social work.

### **Use of Self**

"Use of self" was defined broadly in the literature, with "self-disclosure" occupying just a sliver of the definitions posed by authors of a majority of existing articles on the subject (Reupert, 2007; Dewane, 2006; Arnd-Caddigan & Pozzuto, 2007; Edwards and Bess, 1998). Therefore, it was surprising to me how often respondents defined "use of self" straightforwardly as some form of self-disclosure, in and of itself. Understanding "use of self" as self-disclosure alone embodies a limited view, given the rootedness of "use of self" as a more full-bodied concept within our profession. Also, a growing body of knowledge within the field of neuroscience suggests that the healthy presence of a comprehensive therapeutic "self" is an integral part of the creation of new, healthier attachment pathways in the brains of clients with disrupted attachment patterns

(Badenoch, 2008). This research has proven what has been an intuitive cornerstone in the field of mental health for years: that a secure therapeutic relationship with an attuned provider creates a safe haven for the exploration of new, healthier ways of responding and being responded to in the world. While this is an emerging science, and may not be common knowledge amongst LICSWs, it is important for those teaching clinical social work skills in universities or through clinical supervision to have strong awareness of the all-encompassing meaning of the “self” that we bring into interaction with those we provide service to. This will increase the likelihood that future clinical social workers will understand, explore, and fine-tune the “self” as the instrument that they bring into therapeutic work with others.

Of course, we must consider the likelihood that those who identified “use of self” as solely “self disclosure” do, in fact, use the “self” in therapy in a way that is more consistent with the broader definition of the concept of “use of self” as defined in the literature. Thus, an interview format may have produced results more strongly parallel to the multi-faceted definition of “use of self” posed elsewhere. However, the fact that the most weighted definition of “use of self” by participants in this study was more or less “use of self-disclosure” does leave one to wonder if the concept of “use of self” in its entirety would be lost in the supervisory hour or in the classroom.

About half of the participants *did* describe their understanding of “use of self” in a way that resonates more fully with previous research and literature on the subject. For instance, respondents talked about bringing the culmination of their being – education, life experience, self- and value- awareness, and spirituality - into the room, to create an empathic relational space in which therapy can take place. This is in line with research

conducted by Reupert (2007), who interviewed 7 social workers and found similar definitions for the self that they brought into the therapeutic space. One of the participants in her study described “using herself as a point of reference for understanding another and using this understanding to find a connection,” which blends nicely with the responses of participants in the current study who conceptualized “use of self” in a similar way (Reupert, 2007, p. 114). Also, falling into sync with writings on “use of self” in the relational context of therapy, participants in the current study noted the significance of the therapeutic self as a function of the therapeutic relationship, and expressed faith in the therapeutic relationship as a healing agent (Arnd-Caddigan & Pozzuto, 2008, Edwards & Bess, 1998).

**Authenticity and genuineness.** Two standout words that came up during content analysis were “authenticity” and “genuineness.” Although the essence of these synonyms is perhaps implied in the results of previous empirical research on “self,” neither “authenticity” nor “genuineness” came up in the research or scholarly writing reviewed for this study. Participants in the current study described “use of self” as bringing an authentic self into therapy sessions, “being genuine and real,” and simply “genuineness.” It is surprising that the use of these words by study participants seems to be unique to this study. However, as mentioned, studies on clinicians’ subjective interpretation of “use of self,” in general, are scarce. It does not seem too far-fetched to assume that genuineness and authenticity may emerge as themes in future research on use of self.

### **Impact of Personal Therapy on Use of Self**

As mentioned, the responses from participants to the prompt “Please elaborate on

how personal therapy affected your use of self in clinical practice” did not necessarily focus on personal therapy’s impact on their use of self per se. Participants’ comments overall captured the spirit of the clinical “self,” and were, in general, laced with direct observations about how personal therapy affected this sample’s “use of self” in practice. However, responses were predominately focused on the effects that personal therapy had had on participants’ decisions regarding therapeutic technique, development of self-awareness, processing of issues related countertransference, development of healthy boundaries, and experience of occupying the client role. These responses shared many parallels with previous research on the perceived effects of personal therapy on professional development. For instance, many of the LICSWs in this study commented on how their therapists served as models for how to conduct practice on a variety of levels, corroborating several preexisting research studies in which respondents nodded to the powerful learning they found in purposefully or inadvertently observing and integrating their own therapists’ style (Macran, 1999; Oteiza, 2010; Mackey & Mackey, 1993). Similarly, themes unveiled in the current study, such as “having the experience of being a client,” “greater self-awareness,” and “awareness of issues related to countertransference” parallel previous research on the effect of personal therapy on professional development (MacDevitt, 1987; Mackey & Mackey, 1993; Macran, Stiles, & Smith, 1999; Oteiza, 2010; Daw & Joseph, 2007). Finally, two respondents in this study recounted how *negative* experiences in personal therapy informed their use of self with clients of their own. It is notable to mention that previous research has also revealed that even less than ideal experiences in personal therapy can have a positive influence on practice (Grimmer & Tribe, 2001; Macran, 1999).

## **Limitations**

This study had several limitations. First, as mentioned on previous pages, the sample of participants was relatively small and homogenous. Given that all LICSWs in this sample were from Minnesota, the results cannot necessarily be generalized to a broader population of LICSWs. Also, the overall response rate - approximately 23% - was quite low. In addition, it is possible that LICSWs with better experiences in personal therapy were more likely to participate, meaning that the results do not include a proportionate number of responses from those who had past neutral or negative experiences with personal therapy. Finally, the anonymous internet format of the survey used in this study produced shorter responses in general, and no opportunity for follow up questions to responses that I found particularly unique, confusing, interesting, or surprising.

## **Conclusion and Implications for Further Research**

Social workers are human beings, vulnerable as any other to the suffering and complex dilemmas that life inevitably presents. Mountains of evidence imply that personal therapy can be a nurturing and helpful means to therapists' personal and interpersonal growth, wellness, and healing in the face of these challenges. This study provided further evidence for the power that personal therapy can have in the lives of those who have dedicated their own lives to therapeutically joining with others through the ups and downs of time.

In this joining process, it is important to spend ample time reflecting on who we are as we sit across from those coming to us for support. The "self" we bring into the

therapy room as we empathize, connect, share, and respond has the potential to deeply affect those we therapeutically come into contact with. It is our responsibility as clinical social workers, and as mental health care practitioners in general, to ensure that we present our “selves” in a manner that is most likely to promote growth, healing, and empowerment in our clients. This is a career-long process, as we are constantly moved and shaped by our life experiences and by the people with whom we interact - including our clients - in a multitude of ways. Personal therapy provides a safe place for us, as mental health care professionals, to work through our own dilemmas while simultaneously sharpening, polishing, and refining the “self,” we bring into the therapeutic space.

### **Future Research**

Further research may continue to investigate how social workers conceptualize “use of self” in therapeutic practice, and may also look more closely at the “self” per se, by asking LICSWs to describe the “self” they bring into the therapeutic relationship, how this “self” came into being, and how this “self” evolves over time. This would provide a more comprehensive picture of the “self” that clinical social workers use in their therapeutic practice with others, and may inform social work programs on the importance of including more comprehensive material on “use of self” in social work education.



## Appendix A - Survey

Author's note: The survey used for this study was an electronic, online survey, which used "skip logic" and "display logic" functions to make the survey more intuitive and easy to navigate for participants. On the following pages, you will find the original survey, which became much less of a difficult to decipher puzzle when I plugged it into Qualtrics survey software. For instance, prompts such as "if yes, proceed to question 3b" were nonexistent on the online survey, as participants were automatically redirected to the next appropriate question, based upon their response.

### **SURVEY: Clinical Social Workers' Use of Self and the Impact of Personal Therapy on Practitioner Development**

Please read the following definition of *personal therapy* and then answer the following questions:

**Personal Therapy:** "A broad and generic term encompassing psychological treatment of mental health professionals (or those in training) by means of various theoretical orientations and therapy formats," that can occur for any duration and that may be "either voluntary or required" (Geller, Norcross & Orlinsky, 2005)

1.) Have you ever sought individual personal therapy?

\_\_\_Yes

\_\_\_No

If **YES**, when were you last in therapy? (each item was yes/no format on Qualtrics)

- ☐ 0-5 years ago
- ☐ 5-10 years ago
- ☐ 10-15 years ago
- ☐ 15-20 years ago
- ☐ 20+ years ago
- ☐ I am currently in personal therapy

If **YES**, please check any of the following that describe your reason for seeking personal therapy and proceed to question 2a: (each item was Yes/No format on Qualtrics)

- |  |  |
|--|--|
| <input type="checkbox"/> Personal problems                           | <input type="checkbox"/> Clinical training     |
| <input type="checkbox"/> Emotional problems                          | <input type="checkbox"/> MSW program mandate   |
| <input type="checkbox"/> Marital (or intimate relationship) problems | <input type="checkbox"/> Substance abuse       |
| <input type="checkbox"/> Other interpersonal problems                | <input type="checkbox"/> Grief/Loss            |
| <input type="checkbox"/> Family difficulties                         | <input type="checkbox"/> Personal growth       |
| <input type="checkbox"/> Work related stress                         | <input type="checkbox"/> Infertility           |
| <input type="checkbox"/> Family of Origin Issues                     | <input type="checkbox"/> Personal Growth       |
| <input type="checkbox"/> Life Transition                             | <input type="checkbox"/> Other _____ (specify) |
| <input type="checkbox"/> Stress in personal life                     | <input type="checkbox"/> Do not wish to answer |

2a.) Do you feel that personal therapy was helpful to you?

- ☐ Yes, personal therapy was helpful to me (**Proceed to QUESTION 2b**)
- ☐ No, personal therapy was not helpful to me. (**Proceed to SECTION 3a.**)

☐ I have had both good and bad experiences in personal therapy (**Proceed to QUESTION 2b**)

☐ Do not wish to answer

2b.) Please check any of the following that describe how personal therapy was helpful to you and proceed to question 3a: (each item was yes/no format on Qualtrics)

- |   |   |
|---|---|
| <input type="checkbox"/> Alleviation of symptoms        | <input type="checkbox"/> Better understanding of self |
| <input type="checkbox"/> Positive cognitive changes     | <input type="checkbox"/> Resolution of past trauma    |
| <input type="checkbox"/> Positive affective changes     | <input type="checkbox"/> Resolution of grief          |
| <input type="checkbox"/> Positive behavioral changes    | <input type="checkbox"/> Enhanced personal growth     |
| <input type="checkbox"/> Better self-image              | <input type="checkbox"/> Better relationships         |
| <input type="checkbox"/> Other (Please describe: _____) |   |
| <input type="checkbox"/> Do not wish to answer          |   |

3a.) Do you feel that personal therapy has had an impact on your *professional development*?

☐ Yes, personal therapy impacted my professional development (Please answer question 3b)

☐ No, personal therapy feels unrelated to my professional development (Proceed to question 4a)

☐ Do not wish to answer

3b.) Check any of the following statements that describe the way or ways that personal therapy impacted your *professional development* and then proceed to question 4a:

**My therapist served as a model for how to:** (each item was Yes/No format)

☐ professionally conduct practice

☐ theoretically conduct practice

☐ interpersonally conduct practice.

**Personal therapy helped me to better:** (each item was Yes/No format)

☐ understand my clients and their process in therapy.

☐ empathize with my clients and their process in therapy.

☐ trust my clients and their process in therapy.

☐ respect my clients and their process in therapy.

☐ Personal therapy oriented me to the role of a therapist.

☐ Personal therapy helped me to understand the therapeutic process.

☐ Personal therapy helped me to understand how my personal life influences my professional life.

☐ Personal therapy helped me to better understand the therapeutic relationship.

☐ Personal therapy helped me to better understand transference and/or countertransference.

☐ Personal therapy provided me with an outlet for self-care

☐ Personal therapy had a *negative* impact on my professional development.

☐ Other (Please comment in space below)

☐ I do not wish to answer this question.

4a.) In social work, we often talk about the importance of the “use of self” in our work with clients. Do you believe that personal therapy has had a positive effect on your “use of self” in clinical social work practice, based on your own subjective understanding of the term “use of self”?

☐ Yes

☐ No

If **YES**, please elaborate in the space below:

4b.) What does “use of self” mean to you as a clinical social worker?

Please answer the following demographic questions.

5.) How many years have you been in clinical social work practice?

7.) What type of therapy do you practice in your current setting? Please check all that apply.

☐ Individual – Adult

\_\_Individual – Child

\_\_Individual – Adolescent

\_\_Family

\_\_Couples

\_\_Group Work – Adult

\_\_Group Work – Child

\_\_Group Work - Adolescent

8.) What is your age?

9.) What is your gender?

**APPENDIX B – Email to participants**

Dear LICSW:

Hello! My name is Jessie Daley. I am a clinical year graduate student in the Master of Social Work program at University of St. Thomas/St. Catherine University. I am writing to invite you to participate in my clinical research project entitled “Clinical Social Workers’ Use of Self and the Effects of Personal Therapy on Practitioner Development.” This study is being conducted under the supervision of Dr. Kendra Garrett, Ph.D, MSW, LICSW. You were randomly selected as a candidate for participation from a larger random sample of LICSWs I received from the Minnesota Board of Social Work.

The purpose of this anonymous internet study is to explore clinical social workers’ experiences in personal therapy, namely if and how the experience of being involved in therapy has affected their personal development, professional development, or their professional “use of self” in the clinical setting. I am also interested in exploring what “use of self” subjectively means to clinical social workers in practice, and as such, am interested in collecting responses from LICSWs regardless of whether or not they have had experience in personal therapy.

This study is entirely voluntary. If you choose to participate, you are free to skip any questions or to discontinue participation in the study at any time.

If you DO choose to participate in this study, please click on the link below, which will redirect you to an electronic consent form and the anonymous electronic survey:

\*\*\*SURVEY LINK APPEARED HERE\*\*\*

Thank you for considering participation in this study...  
I hope this winter is treating you well,

Jessie Daley  
Master of Social Work Student  
University of St. Thomas/St. Catherine University

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